VERMONT

www.labor.vermont.gov

STATE OF VERMONT
DEPARTMENT OF LABOR
WORKERS' COMPENSATION DIVISION
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DOL FORM 20 Rev 5/05

State File No. _____

Ins. Co. File No. _____

Date of Injury _____

Fed. ID No. _____

Soc. Sec. No. _____

WORK CAPABILITIES FORM

Form recommended for use by medical providers in assessing work capabilities of patients with work injuries

Employee's Name: _____

Based on my examination of this patient on _____(date)

☐ May **NOT RETURN TO WORK**
☐ May **Return to work** with **no restrictions**
☐ May **Return to work** on _____**with the following capabilities**:

WORK CAPABILITIES – may perform the following:

(a) **Stand/Walk**:
☐ Not at all ☐ 1-3 hrs ☐ 3-5 hrs ☐ 5-8 hrs ☐ Unrestricted

(b) **Sit**:
☐ Not at all ☐ 1-3 hrs ☐ 3-5 hrs ☐ 5-8 hrs ☐ Unrestricted

(c) **Drive**:
☐ Not at all ☐ 1-3 hrs ☐ 3-5 hrs ☐ 5-8 hrs ☐ Unrestricted

(d) **Lift**:
☐ Not at all
☐ No more than 10 lbs. ☐ Occasionally ☐ Frequently ☐ Unrestricted
☐ No more than 20 lbs. ☐ Occasionally ☐ Frequently ☐ Unrestricted
☐ No more than 50 lbs. ☐ Occasionally ☐ Frequently ☐ Unrestricted
☐ No more than 100 lbs. ☐ Occasionally ☐ Frequently ☐ Unrestricted
☐ Unrestricted

(e) **Bend**:
☐ Not at all ☐ Occasionally ☐ Frequently ☐ Unrestricted

(f) **Squat**:
☐ Not at all ☐ Occasionally ☐ Frequently ☐ Unrestricted

(g) **Climb**:
☐ Not at all ☐ Occasionally ☐ Frequently ☐ Unrestricted

(h) **Twist**:
☐ Not at all ☐ Occasionally ☐ Frequently ☐ Unrestricted

(i) **Reach above shoulders**:
☐ Not at all ☐ Occasionally ☐ Frequently ☐ Unrestricted

Specific work capabilities not listed above:_____.
Employee has limited use of: _____.

Employee ☐ can ☐ cannot perform repetitive activities ☐ for more than _____ min/hrs.
Employee ☐ can ☐ cannot work more than 8 hours a day.

☐ Work capabilities are in effect ☐ until _____;or ☐ until further evaluation:

☐ Scheduled for follow-up appointment on _____.

☐ Referred to _____ for follow-up care.

If disabled at this time, estimate duration of total disability:_____.

Comments: _____

_____

_____ _____
Medical Provider's Name (Print) Date

_____ _____
Medical Providers Signature

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize this Medical Provider to release any information acquired in the course of my examination or treatment for the above injury to my employer or its representative.

Patient Signature: _____Date: _____